

**AHIP SPEECH
PALM SPRINGS
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I want to begin by thanking AHIP for giving me the opportunity not only to tell the Pitney Bowes story, but to draw broader lessons for all health plan providers and payers. The topic of my remarks is “Employer Investment in Health: An Emerging Strategy.” It may sound odd to refer to any strategy discussion relating to employer-provided health plans as “emerging” because employers have been providing health benefits for over 60 years, but the logic of having employer plans is compelling and the case has not well-articulated. Today, I hope you come to appreciate not only the logic of employer-provided plans, but the specific approaches we have taken at Pitney Bowes.

(Slide 2) The key theme of my remarks is that health is an investment, not a cost, and that it has a return like any other investment. What proponents of single-payer plans, or consumer-driven health programs fundamentally fail to understand is that employers have a unique combination of reasons for investing in employee health, which I will describe a little later in my remarks.

(Slide 3) First, a little background about Pitney Bowes. As the slide shows, we are an 86-year-old company. Our revenues will top \$6 billion this year, and we have a broad customer base. (Slide 4) In the last 10 years, we have divested all non-core businesses, and have defined our area of focus as the mailstream, which this slide broadly defines. To keep it simple, the mailstream is all content going through the mail, through all carriers,

including all the processes from creation through receipt and response, through all media, physical and electronic. I am proudest of the fact that we have been a steady, consistent, long-term performer in delivering investor value. Jim Collins, in his Good to Great book, highlighted our exceptional performance between 1974 and 12.7% total shareholder return from 1957 through 2003, which, by the way, was about how we did in 2006.

I am also proud of our leadership in employer-provided health care over the last 15 years. (Slide 5) As described in a book written by Dr. Jack Mahoney, our Corporate Medical Director and Dave Hom, our Vice President of Strategic HR Initiatives, these are the seven principles on which our success has been based. These principles are highly inter-related, so I will discuss some of them as part of a review of others.

(Slide 6) The first principle I will discuss is that “Health Begins and Ends with the Individual,” which is a subset of the broader principle that the health of the organization begins with a focus on its people. There are three components to a focus on the individual. The first is the creation of a culture of health and well-being by the Company. We care deeply about our employees, and we also try to create a nurturing environment that optimizes performance. This does not mean we do not work hard or drive strong performance, but I believe that creating an environment of respect for the individual, fairness, ethical business practices, and valuing diversity all contribute to a healthy psychological and social environment that contributes to both physical and behavioral health. We try to treat our employees as people and resources, not as costs.

The second component is the physical environment we create at the worksites we control. We have seven onsite clinics and one onsite pharmacy. We have been a smoke-free workplace since 1990. We are fanatical about the healthiness of the food we serve in our company dining facilities, and we are attentive to the quality of our employee workplaces. In fact, we are doing a renovation of our 20-year-old World Headquarters called the “Here Comes the Sun” project which has a core objective of giving every workspace direct exposure to natural light.

Third, we strongly promote wellness and prevention, through outreach, plan design, and financial incentives, and we make fitness and wellness programs easy to access. Our stated goal of our health plans is to promote health. By the way, I think much of the national and state-by-state debate on health care is badly-flawed because it focuses on access, cost, and allocation of responsibility for payment.

(Slide 7) The goal of health care should be improved health. To get to that goal, which is our primary one, we have three related goals, to maximize appropriate utilization of the right kinds of health resources, to guide our employees to the appropriate selection of health plans and programs, and to deliver the other goals affordably for them and us. Relative to the utilization of health resources, as you will see later, there is some resource utilization we want to promote, and some we want to discourage.

How do we figure out how to achieve these goals? (Slide 8) One of the key messages I want to make sure you take away from this presentation is that everything we do should be guided by rigorous data collection and analysis.

We learn as much as we can about our employees and the other people to whom we provide coverage. We recognize that health care practices vary from community to community, so we are very attentive to geography. In fact, we share benchmark geographic cost data with our businesses to help them price labor-based services, because costs vary significantly, even within relatively small distances.

(Slide 9) We also analyze and try to accumulate total cost data. Remember my comment about the unique value of employer-provided health plans. We are only entity that can make a financial case for investing in health that takes so many different cost factors into account. If an employee population is healthy, we save on health care costs, workers compensation and disability costs, absenteeism costs, and what is now popularly called “presenteeism” costs, that is, costs associated with reduced productivity from employees who are at work, but in less-than-optimum health.

We not only look at current costs, but, more importantly, we look at the risk factors that will produce higher future costs. One of the counter-intuitive conclusion illustrated by the next few charts. (Slide 10) At first glance, we should celebrate the fact that 10% of our population costs us nothing in a given year, but that is too short-term a way of looking at the problem.

Health promotion means that either we or the individual should be spending something to improve health every year. For a healthy individual, that spending may take the form of preventive screenings or immunizations. For individuals with chronic diseases, the spending should be targeted at following a well-designed treatment plan. (Slide 11) Thus, non-users who

are healthy might migrate into the “up to \$1,000” per year spending category, and those with chronic diseases might migrate to the “\$1,000 to \$10,000” per year category if they are adhering to the appropriate treatment plan. (Slide 12) We know that if we do not succeed at these goals, we will end up in the current or future year with a jump from non-use into the “more than \$10,000” year category.

(Slide 13) At the same time, we must combine with the data analysis with a focus on making sure that as we or the individual spend money, we are getting the best possible value from spending. By using the eValue8 tool developed by the National Business Coalition on Health, we are able to determine whether the plans our employees and the families have joined deliver the best health outcomes at the best economic value. Over time, using this and other tools, we have created incentives for employees to elect those plan choices that maximize health and economic value consistent with our strategic goals.

(Slide 14) We also have recognized that, keeping all of the economic benefits of a healthy employee in mind, including reduced absenteeism, disability, and presenteeism, it makes sense for us to have a network of onsite clinics and even one onsite pharmacy. These seven clinics are not only economically successful and a great engine for health improvement, they are extremely popular with employees.

(Slide 15) We also invested in an expanded EAP model with respect to behavior health challenges. We changed the model in 2001 to an assessment and treatment model and expanded from 3 to 8 free visits. As a result, we

have seen a significant improvement in our behavioral health cost experience.

(Slide 16) We also recognized that a core part of the investment in health is providing financial incentives for behaviors that increase their health and our ability to manage health. Our Health Care University initiative, which we began about a decade ago, and which incents health-promoting behaviors has a 24% participation rate, which is phenomenal, considering the fact that many of our employees are either relatively new to more established parts of the Company, or have joined us recently through acquisitions.

(Slide 17) Another core health investment has been in the predictive modeling that enables to test different elements of our benefit plan designs.

(Slide 18) We have focused most on major chronic illnesses that, if we neglected them, would be the fastest-growing and highest cost factors in our plans.

Through the predictive modeling, we have determined that chronic conditions worsen and become significantly more expensive when patients either fail to adhere to a medication program or do not regularly avail themselves of the appropriate preventive and screening services. Recall my earlier comments about non-users being sources of concern rather than celebration.

(Slide 19) To use one example of our predictive modeling, a diabetes patient who is over 22 years old and who meets one of the three conditions shown

on this chart is a candidate for a more-than-\$10,000 cost in the next year. So what have we done with this finding?

(Slide 20) As the chart shows, we offer preventive screenings either free or for a very low co-pay, use low co-payments for physician office visits, increase access to critical information for employees. (Slide 21) Most importantly, because of the criticality of maintenance drugs, we have focused specifically on the levers for higher percentage adherence to maintenance drug treatment plans.

(Slide 22) As this chart indicates, the most important principle is to put target chronic medications on the most affordable tier to increase compliance with a disease management program. This chart illustrates how our plan design varies from a traditional plan design in our focus on investing in specific brand name drugs for asthma, diabetes, hypertension, and other chronic diseases.

(Slide 23) As a result, we have seen a marked change in both medication utilization and compliance with disease management programs. (Slide 24) We have also seen specific savings in reduced costs for diabetes, asthma, pharmacy costs, hospital admissions, emergency room visits, and disabilities. Pharmacy costs are lower because we have a much higher proportion of lower-cost maintenance drugs and a much lower proportion of higher-cost rescue drugs.

(Slide 25) So what has been the long-term effect of our value-based health care program? We kept per-employee costs flat throughout the 1990's, and

have lagged benchmarks cost increases every year since 2000. What this chart does not show is that our demographics have significantly worsened over the last 15 years, with a much higher percentage of lower income, inner-city, older employees and families. Our challenges in reaching these populations have increased because less than 50% of our U.S. employees work on our sites. More than half do labor-based mailroom and copy center management services on customer sites in small pockets that make it difficult to try the approaches that have worked so well on our sites, such as the onsite clinics, the annual screenings and immunizations, and the face-to-face outreach by medical and health-related personnel.

For 2007, we have three priorities:

- (Slide 26) We will extend our investment in prescription drugs for chronic medications, including prenatal vitamins and smoking cessation products.
- (Slide 27) We are working with several large employers and associations to create a personal, private, and portable electronic health record, since we think that is essential for continuous, high-quality, data-driven health care and health plan design.
- We are developing methodologies to figure out how to market the benefits of adherence to more diverse employee and patient populations.

(Slide 28) My final comment is that we cannot do this alone. Ultimately, many of our employees and their families will be members of your plans. We need to partner with you to make sure that your plan designs are

consistent with our philosophy of investing in employee, family, and community health. We need to have a continuing dialogue on how we can learn from you as to some of your best practices, because you are doing many innovative things that are producing good results as well.

We also need to participate together in the national debate on health care that certainly will be a major issue in both state and national elections in 2007 and 2008 and beyond. There are a lot of proposals that, in my opinion, simply fail to get at the fundamental problems of the system. For example, universal coverage is good, but if the coverage is focused on rewarding events of disease treatment rather than prevention, we are setting ourselves up for continuing fast escalation in health care costs.

Consumer-driven health is good, if the consumer is incented to invest in health, not to take money allocated for health and invest it somewhere else. There are good and bad health care spending patterns. Consumer-driven health plans need to be crafted to drive good spending.

I also think elected officials have to take a fundamental look at coverage mandates. Some should be in place for core insured health coverage. Others are nothing more than the results of effective special-interest lobbying. We need to be a voice of reason in this debate.

In conclusion, the equation is simple: it's all about health – healthy citizens in healthy communities.

Thank you very much for giving me the opportunity to speak with you today! I now welcome the opportunity to take your questions.